18-21 Year Old AHCCCS EPSDT Tracking Form

Date: Last Name: First Name: AHCCCS ID#: Age:

Primary Care Provider Name and Office Phone Number: Contractor: DOB:

Accompanied by: Allergies:

Weight: Percentile: Height: Percentile: BMI: Percentile:

HISTORY:

Parental Comments/Concerns:

Vision Chart Exam
OD _____
OS _____
OU _____
Corrected / uncorrected

Temp: _____
Pulse: _____
Resp: _____
BP _____
BP elevated?

Dental Screen: Date of last exam: _____ Next appt: _____ Routine _____ Urgent _____ Parent advised _____

Nutritional Screen: Adequate _____ Inadequate _____ Supplements: _____

Hearing Screen: Within normal limits? Yes _____ No _____ **Speech:** Within normal limits? Yes _____ No _____

Developmental Screen: Age Appropriate? Yes _____ No _____ If suspicious, specific objective testing performed _____

Behavioral Screen: Age appropriate? (HEADDSS, GAPS, parental interview) Yes _____ No _____

PHYSICAL EXAM

Are the following normal?	Yes	No	Describe abnormal findings:
1. Skin/Hair/Nails			
2. Ear/Hearing			
3. Eyes/Vision			
4. Mouth/Throat/Teeth			
5. Nose/Head/Neck			
6. Heart			
7. Lungs			
8. Abdomen			
9. Genitourinary/Breast **Tanner Stage**			
10. Extremities			
11. Spine (scoliosis)			
12. Neurological			

LABS ORDERED:

Tuberculin Test _____
(perform if at risk)

Additional labs ordered:
Hgb/Hct _____
Urinalysis _____
Lipid profile _____
Other tests: _____

Confidential Documentation:

See attached note please: _____

ASSESSMENT & PLAN:

IMMUNIZATIONS: **Pt. needs immunizations?** **Yes** _____ **No** _____ **Delayed?** _____ **Deferred?** _____
Given today? **Hep B** _____ **Td** _____ **MMR** _____ **Influenza** _____ **Varicella** _____ **Hep A** _____ **Other** _____

ANTICIPATORY GUIDANCE

- Drowning/sun safety
- Seat belts/driving safety
- Sports/injury prevention
- Nutrition/exercise
- Dental and self care
- Sex education/counseling
- Self control
- Peer refusal skills
- Social interaction
- Depression/anxiety
- Tobacco/alcohol/drugs/inhalants
- Violence prevention/gun safety
- Education goals/activities
- "Safe at Home?"
- Parenting advice
- Family involvement
- Next appointment

REFERRALS:
Behavioral _____ **Dental** _____ **Nutritional** _____ **WIC** _____ **Developmental** _____ **Specialty** _____ **Other** _____

Yes _____ No _____

Clinician Name (print): Clinician Signature: See Additional/Supervisory Note?

Revised January 1, 2004